



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT OF HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 16, 2010

Thair Pond, Administrator
Tomorrow's Hope-- Eagle
1655 Fairview Avenue, Suite 100
Boise, Idaho 83702

RE: Tomorrow's Hope-- Eagle, Provider #13G047

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Tomorrow's Hope-- Eagle, on September 8, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

Thair Pond, Administrator
September 16, 2010
Page 2 of 2

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 29, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read "Taylor Barkley", with a stylized flourish at the end.

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2010
---	--	--	--

NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven (7) ICF/MR beds. The survey was conducted in accordance with 42 CFR 483.470. The following deficiencies were cited during the fire/life safety survey on September 8, 2010. The annual life safety code survey was conducted by: Taylor Barkley Health Facility Surveyor Fire/Life Safety and Construction Program	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">SEP 21 2010</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
K0011	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility is housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15 minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. All columns, beams, girders, and trusses are similarly encased or otherwise provide not less than a ½ hour fire resistance rating. 33.2.1.3.2. Exception No. 1: Exposed steel or wood columns, girders, and beams (but not joists) located in the basement. Exception No. 2: Buildings of Type I, Type II (2,2,2), Type II (1,1,1), Type III (2,1,1), Type IV	K0011	<p><i>K 0011</i></p> <p><i>Openings found during survey shall be repaired to meet regulations</i></p> <p><i>Maintenance by 10/20/10</i></p> <p><i>Monthly review of house will include inspections for openings</i></p> <p><i>P.Q. responsible by 10/20/10</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2010
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0011	<p>Continued From page 1 (1,1,1) construction (See 8.2.1)</p> <p>Exception No. 3: Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5.</p> <p>Exception No. 4: Unfinished, unused, and essentially inaccessible loft, attic, or crawl space.</p> <p>Exception No. 5: Where the facility achieves an E-score of three or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety.</p> <p>This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that the interior is fully sheathed with lath and plaster or other material providing a 15 minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. The facility had a census of seven clients on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 8, 2010 at 9:50 AM, observation of the ceiling in the lower level furnace room had openings approximately one foot by two foot, one foot by one foot, and six inches by one foot in sizes cut out of it. The findings were observed and noted by Surveyor and the Facility Manager. This deficiency affected seven clients and two staff in one of two smoke compartments.</p>	K0011			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2010
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2010
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven (7) ICF/MR beds. The survey was conducted in accordance with applicable fire/life safety requirements set forth in IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR).</p> <p>The following deficiencies were cited during the fire/life safety survey on September 8, 2010.</p> <p>The annual life safety code survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Fire/Life Safety and Construction Program</p>	M 000	<p>RECEIVED</p> <p>SEP 21 2010</p> <p>FACILITY STANDARDS</p>	
MM345	<p>16.03.11.110.06(f) Portable Fire Extinguishers</p> <p>Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers." This Rule is not met as evidenced by:</p> <p>Based on observation it was determined that the facility failed to ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of seven clients on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 8, 2010 at 9:52 AM, observation of the lower level portable fire extinguisher revealed that the last monthly inspection noted on the affixed tag was in July of</p>	MM345	<p><i>MM345</i></p> <p><i>Extinguisher missed at last inspection. Staff trained to check all extinguishers during monthly checks. DQ responsible by 10/20/10</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2010
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM345	Continued From Page 1 2010. The findings were observed and noted by Surveyor and the Facility Manager. NFPA 10 - 1998 Edition 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	MM345		